TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WILLIAM STRINDEN, MD

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-17-0289-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
OCTOBER 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please refer to the Medicare policy on use of the operating microscope which states 69990 can be used with 64831 and 64832. The fact that other structures were also repaired should not make the use of 69990 invalid."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2016	CPT Code 26356-58	$0.00	$0.00
	CPT Code 35207-58-51	$0.00	$0.00
	CPT Code 64832-58-51	$0.00	$0.00
	CPT Code 64832-58	$0.00	$0.00
	CPT Code 69990-58-59	$600.00	$0.00
	CPT Code 12002-58-59	$0.00	$0.00
TOTAL		$600.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
    - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
    - 908-Per the CCI Edits, this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day.
    - 350-Bill has been identified as a request for reconsideration or appeal.
    - B13-Re-evaluated; no additional payment is recommended.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 12, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the allowance of code 69990-58-59 included in the allowance of another code? Is the requestor entitled to reimbursement?

Findings

The disputed issue is whether the requestor is due reimbursement for code 69990-58-59 per 28 Texas Administrative Code §134.203.

On the disputed date of service the requestor billed codes 26356, 35207, 64831, 64832, 69990 and 12002. The requestor appended modifiers "59-Distinct Procedural Service" and "58- Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period".

According to the explanation of benefits, the respondent denied reimbursement for code 69990-58-59 based upon "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated," and "908-Per the CCI Edits, this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day."

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

Per CCI edits, CPT codes 69990 is included in the allowance of codes 12002 and 26356 and a modifier is not allowed to differentiate the service; therefore, the respondent's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/12/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.